



SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING AND REGULATION
BOARD OF EXAMINERS IN OPTOMETRY
PO BOX 11329
COLUMBIA SC 29211-1329
(803) 896-4679

2015-2016 OPTOMETRY RENEWAL FORM

Name: _____ **License #** _____

Instructions

1. **Renew online at <https://renewals.llronline.com> You must have your user ID and Password to renew online. – OR–**
 2. Answer all the questions on both pages of this renewal form. Sign the form. **Incomplete forms will be returned.**
 3. Include renewal fee and **make check payable to: SC Board of Examiners in Optometry.** Return all parts of this form.
Mail completed **renewal form and correct fee to:**
SC LLR Board of Examiners in Optometry, PO Box 11329, Columbia, SC 29211-1329
 4. If you have questions, visit the Board's webpage at www.llr.state.sc.us/pol/Optometry/.
 5. **Due Date: Postmarked on or before December 31, 2014. License will lapse if not renewed by February 1, 2015**
 6. **Continuing Education Required:** 40 hours obtained since 10/01/2012 (16 of the 40 hours must be pharmacology or pathology related)
- The Board will conduct a random CE audit after 2/1/2015. If you are audited, you will be required to submit proof of CE at that time. **DO NOT** send CE to the Board office unless instructed to do so.

Fee Schedule

Biennial Renewal Fee: \$230.00 **OR** if you practice at **multiple SC locations:** \$230.00 per SC practice location
Late Fee: \$50.00 + renewal fee if postmarked 1/1/2015 - 1/31/2015
Reinstatement Fee: \$100.00 + renewal fee if postmarked after 1/31/2015

Home Address

Primary Practice Location

Mailing Address

Phone: _____
Fax: _____
E-mail: _____
Congressional District: _____

Phone: _____
Fax: _____
E-mail: _____
Congressional District: _____

Phone: _____
Fax: _____
E-mail: _____
Congressional District: _____

Continuing Education

1. Have you completed the required number of CE hours for this license for the renewal period? ☐ Yes ☐ No

If you answer "Yes" to any of the following questions, attach a full written explanation along with a copy of the Order or other relevant documentation.

2. Since you last renewed your license, have you been involved in any pre-trial intervention program, been convicted, pled guilty, or pled nolo contendere (no contest) for the violation of any federal, state or local law or do you have charges pending (other than a minor traffic violation)? Yes ☐ No ☐
3. Since you last renewed your license, have you had an application for a professional license, examination, certification or registration denied or refused by any licensing board or other entity, or have you ever surrendered a professional license? Yes ☐ No ☐
4. Since you last renewed your license, have you developed or been treated for any disease or condition, physical, mental, or emotional (including alcohol or other substance abuse) that may render further practice dangerous to the public? Yes ☐ No ☐
5. Since you last renewed your license, have you been addicted to or used in excess any drug or chemical substance, including alcohol, or been treated for a drug or alcohol addiction or participated in a rehabilitation program? Yes ☐ No ☐
6. Since you last renewed your license, have you had any investigation, formal complaint, disciplinary action or consent order filed against you by any person, employer, or licensing board in any jurisdiction? Yes ☐ No ☐
7. Since you last renewed your license, has your ability to prescribe controlled substances ever been surrendered, revoked, suspended, limited or restricted? Yes ☐ No ☐
8. Has there been any change in the status of your lawful presence in the United States since initial licensure? Yes ☐ No ☐

Licensed States

9. List all other states in which you currently or have previously been licensed as an Optometrist. _____

South Carolina Practice Locations

10. Do you have an additional practice location (s) in SC not listed on this form? Yes ☐ No ☐

If Yes, you will need to download a Branch Office Registration form from the Board's website and mail it with your renewal form.

Please list your SC practice location(s) below.

Primary Practice Location

Phone: _____

Hrs Per Week: _____

Primary Practice Setting - Mark only one.

- | | |
|---|---|
| <input type="checkbox"/> 11 Hospital Non Fed General | <input type="checkbox"/> 24 Hospital Non Fed Rehab |
| <input type="checkbox"/> 13 Optometric Center/Clinic | <input type="checkbox"/> 22 Federal Non Military Health Facility |
| <input type="checkbox"/> 12 Nursing Home/Other Institution | <input type="checkbox"/> 33 University/College Other |
| <input type="checkbox"/> 23 Hospital Non Fed Psychiatric | <input type="checkbox"/> 36 Tec/Junior College |
| <input type="checkbox"/> 21 Federal Military Health Facility | <input type="checkbox"/> 48 Other Government |
| <input type="checkbox"/> 15 Private Office | <input type="checkbox"/> 71 Other, Specify _____ |

Second Practice Location

Phone: _____

Hrs Per Week: _____

Second Practice Setting:

- | | |
|---|---|
| <input type="checkbox"/> 11 Hospital Non Fed General | <input type="checkbox"/> 24 Hospital Non Fed Rehab |
| <input type="checkbox"/> 13 Optometric Center/Clinic | <input type="checkbox"/> 22 Federal Non Military Health Facility |
| <input type="checkbox"/> 12 Nursing Home/Other Institution | <input type="checkbox"/> 33 University/College Other |
| <input type="checkbox"/> 23 Hospital Non Fed Psychiatric | <input type="checkbox"/> 36 Tec/Junior College |
| <input type="checkbox"/> 21 Federal Military Health Facility | <input type="checkbox"/> 48 Other Government |
| <input type="checkbox"/> 15 Private Office | <input type="checkbox"/> 71 Other, Specify _____ |

Third Practice Location

Phone: _____

Hrs Per Week: _____

Third Practice Setting:

- | | |
|---|---|
| <input type="checkbox"/> 11 Hospital Non Fed General | <input type="checkbox"/> 24 Hospital Non Fed Rehab |
| <input type="checkbox"/> 13 Optometric Center/Clinic | <input type="checkbox"/> 22 Federal Non Military Health Facility |
| <input type="checkbox"/> 12 Nursing Home/Other Institution | <input type="checkbox"/> 33 University/College Other |
| <input type="checkbox"/> 23 Hospital Non Fed Psychiatric | <input type="checkbox"/> 36 Tec/Junior College |
| <input type="checkbox"/> 21 Federal Military Health Facility | <input type="checkbox"/> 48 Other Government |
| <input type="checkbox"/> 15 Private Office | <input type="checkbox"/> 71 Other, Specify _____ |

Fourth Practice Location

Phone: _____

Hrs Per Week: _____

Fourth Practice Setting:

- | | |
|---|---|
| <input type="checkbox"/> 11 Hospital Non Fed General | <input type="checkbox"/> 24 Hospital Non Fed Rehab |
| <input type="checkbox"/> 13 Optometric Center/Clinic | <input type="checkbox"/> 22 Federal Non Military Health Facility |
| <input type="checkbox"/> 12 Nursing Home/Other Institution | <input type="checkbox"/> 33 University/College Other |
| <input type="checkbox"/> 23 Hospital Non Fed Psychiatric | <input type="checkbox"/> 36 Tec/Junior College |
| <input type="checkbox"/> 21 Federal Military Health Facility | <input type="checkbox"/> 48 Other Government |
| <input type="checkbox"/> 15 Private Office | <input type="checkbox"/> 71 Other, Specify _____ |

Activity Status and Primary Form of Practice**11. Current Activity Status - Mark only one.**

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> 01 Currently Practicing Profession | <input type="checkbox"/> 02 Not Currently Practicing Profession | <input type="checkbox"/> 08 Retired |
| <input type="checkbox"/> 18 Out-of-State | | |

12. Current Primary Form of Practice - Mark only one.

- | | | |
|---|---|---|
| <input type="checkbox"/> 11 Self Solo | <input type="checkbox"/> 35 Federal Military | <input type="checkbox"/> 14 Self Group Multi Spec |
| <input type="checkbox"/> 12 Partnership Practice | <input type="checkbox"/> 21 Employed Individual Practitioner | <input type="checkbox"/> 23 Employed by Practitioner Group |
| <input type="checkbox"/> 25 Other Private Employer | <input type="checkbox"/> 34 Federal Civilian | <input type="checkbox"/> 28 Non-Profit Health Agency |
| <input type="checkbox"/> 71 Other, Specify _____ | | |

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately, and completely. I hereby acknowledge that failure to answer these question truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina license.

Signature _____

Date _____